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Refugee Health and Wellbeing Showcase, 21 June 2019
ACKNOWLEDGEMENTS

• Participants from refugee backgrounds
• Services and stakeholders
• Peer researchers
• Mater/UQ Centre for Integrated Care & Innovation
• Queensland Department of Health
• Mr Rupesh Gautam, QUT
• School of Public Health & Social Work, QUT
OUTLINE

• Aims of the evaluation
• Evaluation design and methods
• Peer researcher model
• Baseline data collection key findings
AIM OF THE EVALUATION

To assess whether or not the policy has enabled five key principles:

- Collaboration and Partnerships
- Cultural responsiveness
- Consumer and community voice
- Continuous improvement
- Clinical excellence
EVALUATION DESIGN AND METHODS

- Pre (2018) and Post (2020)
- Mixed methods
- Trained peer researchers (n=14)
- Greater Brisbane, Toowoomba and Cairns
- Mater Misericordiae Human Research Ethics Committee approval

- Patient Experience Survey: Quantitative survey with a random sample of recently arrived refugee background participants (n=63)
- Patient Experience Qualitative Interview: Semi-structured qualitative interviews with convenience sample of refugee background families (n=53)
- Services and Stakeholders Experience Online Survey (n=69)
LIMITATIONS

- Data collected July–October 2018, one year after Policy officially launched. Difficult to ascertain whether or not some of the findings are the result of actions/strategies already implemented.

- Lower than expected response rate among services and stakeholders survey. Respondents were from a range of areas of practice including HHS/other hospital, general practices, Queensland Health, non-government community sector, and settlement services.

- No asylum seekers participated in surveys/interviews.
PEER RESEARCHER MODEL: ADVANTAGES

- Familiar socio-cultural settings
- Trauma-informed / shared experiences
- Invisibility – blending in
- Rapport with participants / access / trust
- Linguistic and non-verbal cultural competence
- Greater appreciation of complexity of participants’ social world
- Cost-effective / interpretation of findings
- Building capacity of communities to research themselves
PEER RESEARCHER MODEL

CHALLENGES/DISADVANTAGES

• Personalised relationships
• Multiple roles and no clear boundaries (researcher, community leader, friend, etc.)
• Participants’ expectations
• Anonymity and confidentiality
• Sampling bias
• Filtering of findings
• Intra-community politics

STRATEGIES

• Training
• Supportive supervision
• Clarification of roles
• Clear communication with participants
• Reflective practice
The Bridge

Group of 11

Refugee communities

Health Information to community
- Forums
- Pass on information informally to community
- Ongoing engagement

Information to the Health System
- Policy input
- Service input
- Clinical education
- Working groups
- University research

Health System
Key findings
Patients’ experiences

- **94%** Had visited a GP in previous 6 months
- **55%** Had visited a Dentist in previous 6 months
- **44%** Had visited a Medical Specialist
- **86%** Had a preferred GP
- **21%** Had been in ED
- **21%** Had been admitted to hospital

Mostly positive experiences with health care services

GPs and case workers / settlement services were the best and most common sources of advice and guidance re: accessing healthcare
Patients’ experience of health services – comparison between survey respondents and the overall Australian population*

<table>
<thead>
<tr>
<th>Experience of health services</th>
<th>Respondents from refugee backgrounds (18+ years – over last 6 months)</th>
<th>Overall Australian population (15 years and over – last 12 months)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saw a general practitioner</td>
<td>94%</td>
<td>84.3%</td>
</tr>
<tr>
<td>Received a prescription for medication</td>
<td>79.4%</td>
<td>69.7%</td>
</tr>
<tr>
<td>Saw a medical specialist</td>
<td>44%</td>
<td>37.4%</td>
</tr>
<tr>
<td>Saw a dental professional</td>
<td>55%</td>
<td>50.1%</td>
</tr>
<tr>
<td>Visited hospital emergency department</td>
<td>21.3%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Admitted to hospital</td>
<td>21.2%</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

Difficult experiences

21% couldn’t see a dentist when needed (mostly due to cost)

21% couldn’t see a medical specialist when needed

27% couldn’t get prescribed medication due to cost

Interpreter services offered when needed:
- Pharmacy (2%)
- ED (44%)
- GP (64%)

Language barriers
Lack of formal health check up on arrival
Developing trust due to past experiences
Lack of familiarity with Australian healthcare system
PATIENTS’ EXPERIENCES

“Yes, my family have regular GP that we visit all the time. From the beginning we were referred by XXX to GP and find out he was good GP. Since then we did not think to change other doctor because I visited other doctors whom I did not like the way they approach us. My regular GP knows that I don’t speak much English and that I have not been in Australia for long time as such he is very patient with me and takes his time when asking me some questions. He also books interpreter for my family all the time”

“The only issue is that my GP does not use interpreter. For example my first appointment, I visited my GP with my case worker and interpreter on phone will explain but since I have been here for sometimes my GP does not use interpreter anymore. If I don’t understand, he writes on paper from Google translation. Possibly will be much better if my GP could provide me an interpreter”
Services and stakeholders experiences

- **64%** Saw clients not proficient in English in last 12 months
- **90%** Involved in at least one Refugee Health Network QLD activity
- **68%** Had partnered with other agencies to improve refugee health outcomes
SERVICES AND STAKEHOLDERS’ EXPERIENCES

“We provide acute care services and health screening for newly arrived refugees (around 2-500 patients per year). In addition we provide ongoing care to patients of refugee background with one in seven of our consultations being delivered through interpreters. All of our staff have attended cultural awareness training and we are actively trying to improve health literacy, social cohesion and the availability of CALD health workers in our region...”

“One in seven of our consultations uses an interpreter. We use hundreds of interpreters every week. We often find XXX interpreters to be of poor quality, doing household tasks whilst doing interpreting by phone, or not available as they are such small language groups. We believe that XXX pays the lowest amount, hence the more experienced interpreters move from XXX to other providers. With the lack of compulsory health care training required of interpreters there is hugely variable quality and ability to really rely on interpreters. This needs to be addressed”
Gaps identified by services and stakeholders

- Funding of services/programs
- Language services
- Communication and collaboration
- Cultural responsiveness
- Health information and education
- Prevention
- Older refugees
- Disability
- Gaps in regional areas
- Greater dissemination of policy & action plan
- Workforce needs
High proportion refugee background patients have a preferred GP who coordinates their healthcare.

Most services collect: COB, preferred language, interpreter requirements.

Limited access to interpreters: pharmacies, EDs, private dentists, some GPs. Family members commonly used as interpreters.

Good levels of collaboration & partnership

Moderate to good levels of participation in RHNQ

Moderate to high levels of engagement of refugee background clients in service planning, development and/or evaluation
Continuous improvement

Clinical excellence

Services & stakeholders:
Low attendance to training sessions on refugee health and wellbeing

High access to RHNQ resources
These resources are highly valued

Patients report high levels of satisfaction with quality of healthcare services

Patients value:
• Caring/respectful attitude of healthcare staff
• Thoroughness of health assessments
• Clear and useful health advice

Concern – barriers when accessing prescribed medications, dental services and medical specialists
Thank you!